OKLAHOMA LAW ENFORCEMENT

RETIREMENT SYSTEM

Application for Disability Benefit

I,_______________________________________, am making application to the Board of Trustees of the Oklahoma Law Enforcement Retirement System, "OLERS", do hereby request to terminate my employment with my agency and start receiving a monthly disability pension as I am no longer able to perform the duties of my occupation or service for which I am qualified and I am unable to perform another service to my agency. Also, I attest the reason I am leaving my agency is wholly due to my disability and I have been informed by my agency there is no other service, regardless of occupation, I can provide to the agency. (Oklahoma Statute Title 47, Sections 2-300(11) and 2-305; OAC 395:10-1-13)

_________ (initial) I understand if the OLERS Board determines that my application is fraudulent the OLERS Board will prosecute under Title 47, Section 2-312.

_________ (initial) I understand if I am applying for a service connected PTSD disability, I MUST show that I have notified my agency that I believe that PTSD may have occurred AND I will provide the incident report and/or evidence of job related condition. Also, I understand that OLERS will not send me for medical evaluation without this information.

_________ (initial) I understand the OLERS Board reserves the right to require a polygraph test in connection with my claim of disability.

I am declaring that my disability is: (check one)

☐ Non-Service Related ☐ Service Related

Applicant Information

Agency Currently Employed With ____________________

SSN ____________________ Birth Date ____________________

Driver's License Number ____________________ Current Age ____________________

Nature of Injury ____________________

Service End Date ____________________ Pension Start Date ____________________

Address ____________________

City ____________________ State __________ Zip Code ____________________

Home Phone ____________________ Cell Phone ____________________

Email ____________________

Admin Actions __________ Data Entry __________ Reviewed __________ Approved __________

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

THE INFORMATION PROVIDED IN THIS APPLICATION IS NECESSARY FOR THE BOARD TO MAKE AN INFORMED DECISION CONCERNING YOUR APPLICATION FOR DISABILITY. FAILURE TO COOPERATE FULLY BY NOT ANSWERING ALL QUESTIONS COMPLETELY, TRUTHFULLY AND ACCURATELY CAN RESULT IN DELAYS, DENIAL OF YOUR CLAIM, OR FRAUD PROSECUTION.

Background Information:

1. Educational background? (check one)
   - ☐GED
   - ☐High School
   - ☐Some College
   - ☐College
   - ☐Post-Graduate
   - ☐Doctorate
2. Address where you worked for your employer?
   a. Address____
      City_____________________________State____ Zip_________
   b. Phone Number_________________
3. Last day on payroll for your employer? ____
4. Position or Title held with your employer? ____
5. What were your actual duties for your employer?__________________________________
6. How long did you work in this position? Years______ Months ______
7. Did you hold a previous position(s) with your current employer? ☐Yes ☐No
   a. If yes, how long were you in each position?
      i. Position Title _______________________ Years______ Months ______
      ii. Position Title _______________________ Years______ Months ______
      iii. Position Title _______________________ Years______ Months ______
8. Are you currently employed outside of your employing agency? ☐Yes ☐No
   a. If yes, give the name, address and telephone number of each current employment (including self-employment) other than the employment which allows you to be a member of this System.
      i. Employer Name____
         1. Address____
            City_____________________________State____ Zip_________
         2. Phone Number_________________
      ii. Employer Name____
         1. Address____
            City_____________________________State____ Zip_________
         2. Phone Number_________________

Applicant's Name_____________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Background Information (continued):

9. Have you ever received any type of medical or disability retirement? ☐Yes ☐No
   a. If yes, please provide the name, written documentation, nature of the disability, address of the entity from which you receive the retirement, and the amount or amounts of retirement received.
      i. Medical/Disability Retirement Name_______________________________________
      ii. Nature of Medical/Disability Awarded_______________________________________
      iii. Retirement Amount______________
      iv. Address____
      City___________________________State____ Zip_________
      v. Written documentation attached? ☐Yes ☐No
10. Have you ever been awarded disability from the Military, State or Social Security? ☐Yes ☐No
    a. If yes, please provide the nature of the disability, the amount and written documentation.
       i. Nature of Medical/Disability Awarded_______________________________________
       ii. Disability Amount______________
       iii. Written documentation attached? ☐Yes ☐No
11. Have you ever received Worker's Compensation benefits? ☐Yes ☐No
    a. If yes, please provide the name, written documentation, nature of the injury, address of the entity from which you receive the retirement, and the amount or amounts of retirement received.
       i. Company/Agency____
       ii. Nature of injury Awarded____
       iii. Award Amount______________
       iv. Written documentation attached? ☐Yes ☐No
12. Have you ever been awarded a personal injury settlement? ☐Yes ☐No
    a. If yes, please provide the nature of the injury, the amount and written documentation.
       i. Nature of Injury Awarded____
       ii. Award Amount______________
       iii. Written documentation attached? ☐Yes ☐No
13. Have you ever been awarded a monetary judgment as a result of a personal injury accident? ☐Yes ☐No
    a. If yes, please provide the nature of the injury, the amount and written documentation.
       i. Nature of Injury Awarded____
       ii. Award Amount______________
       iii. Written documentation attached? ☐Yes ☐No

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information:

14. Why are you currently asking the OLERS for a non-service or service related disability retirement?____
____
____
____
____
____
____

15. State which part or parts of your body have been injured for which you are seeking disability?
____

16. Is this claimed disability related or caused by your employment? ☐Yes ☐No
    a. If yes, why or how?
    ____
    ____
    ____
    ____

17. Is this disability unrelated to your employment? ☐Yes ☐No
    a. If yes, why or how? ____
    ____
    ____
    ____

18. Describe in detail the injury you claim is the basis for your OLERS disability retirement.
____
____
____
____
____

19. Give details concerning the source or cause of the problem which is causing you to seek a disability retirement?____
____
____

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

20. Describe the incident(s) which you assert caused your injury? ______________________________
    ____
    ____
    a. When did this incident(s) occur? ____
    b. Was this incident(s) reported to your employer? ☐Yes ☐No
        i. How? ____
    c. Was there a written report made to document this incident(s)? ☐Yes ☐No
        i. If yes, is all the written documentation attached? ☐Yes ☐No
    d. When did you first seek medical treatment for the injury? ___________________________
    e. Please give the name and address of the treatment provider, date or dates of treatment, and the nature of the treatment.
        i. Treatment Provider____________________ Date of Treatment___________
            1. Nature of Treatment____
            2. Address____
               City_____________________________State____ Zip__________
            3. Phone Number________________
        ii. Treatment Provider____________________ Date of Treatment___________
            1. Nature of Treatment____
            2. Address____
               City_____________________________State____ Zip__________
            3. Phone Number________________
    f. Did you have any follow up evaluations or treatment by other physicians or medical personnel? ☐Yes ☐No
        i. If yes, please give the name and address of the treatment provider, date or dates of treatment, and the nature of the treatment.
            1. Treatment Provider___________________Date of Treatment___________
                a. Nature of Treatment______________________________________
                b. Address____
                   City_____________________________State____ Zip__________
                c. Phone Number________________
            2. Treatment Provider___________________Date of Treatment___________
                a. Nature of Treatment______________________________________
                b. Address____
                   City_____________________________State____ Zip__________
                c. Phone Number________________
21. Who caused you to see or referred you to see the above-referenced physicians or medical personnel? ____
22. Prior to the date of the incident which is giving rise to your claim for disability, had you ever sustained any similar injury or suffered similar problems? ☐Yes ☐No
    a. If yes, please provide the details.____

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

23. Please provide a list of all medical personnel, doctors, physicians, chiropractors, etc., you have seen in connection with the medical problem or injury which is the basis for your claim along with their name, address, telephone number and the date and reason for your visit, examination or treatment.
    a. Treatment Provider____________________ Date of Treatment____________
        i. Nature of Treatment____
        ii. Address____
            City_____________________________State____ Zip__________
        iii. Phone Number_________________
    b. Treatment Provider____________________ Date of Treatment____________
        i. Nature of Treatment____
        ii. Address____
            City_____________________________State____ Zip__________
        iii. Phone Number_________________
24. List the names of any person who has personal knowledge of your accident or disability which is the basis for your claim. ____
    ____
    ____
    ____
    ____
25. Following treatment of your injury, has the treating physician or any doctor released you to return to work? ☐Yes ☐No
    a. Did this doctor place any work restrictions on you? ☐Yes ☐No
        i. If yes, what were the work restrictions placed upon you by this doctor? _________
            ____
            ____
            ____
    b. Please submit the name and address of this doctor
        i. Treatment Provider____________________ Date of Treatment____________
            1. Nature of Treatment____
            2. Address____
                City_____________________________State____ Zip__________
            3. Phone Number_________________
    c. Written documentation attached? ☐Yes ☐No
26. If you cannot perform the job tasks in your currently assigned position, please state why?
    ____
    ____
    ____
    ____

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

27. If you cannot perform your current job tasks, can you perform any service or occupation for your employer? ☐Yes ☐No
    a. If yes, what service or occupation____
28. Has your employer told you that you can't return to work? ☐Yes ☐No
    a. If yes, who told you that you couldn't return? ____________________________________
    b. Why? ____
    c. When? ____
29. Have you filed any type of grievance against your employer as a result of being told you could not return to work? ☐Yes ☐No
    a. If yes, attach documentation.
30. Do you wish to return to work for your employer? ☐Yes ☐No
    a. If no, explain why?____

       ____

       ____
31. Between the last day of work performed for your agency employer and today, have you performed and/or been paid for any other type of employment? ☐Yes ☐No
    a. If yes, When: ____
    b. Name_____________________________________
       i. Address____
          City____________________________State____ Zip_________
       ii. Phone Number_________________
    c. Duties: ____
32. Since your injury, would you be willing to provide copies of any income, income statements, pay stubs, and your income tax returns including W-2s or 1099? ☐Yes ☐No
    a. If yes, please produce copies of any income, income statements, pay stubs, W-2s or 1099s from the date of your injury until present. Copies attached? ☐Yes ☐No
33. What efforts have you taken to attempt to rehabilitate yourself following your injury?

    ____

    ____

    ____

    ____
    a. Please submit any documents which show your efforts to rehabilitate. Documentation attached? ☐Yes ☐No

Applicant's Name______________________________

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

34. Do you have any other health problems? ☐Yes ☐No
    a. In your opinion, have any of these health problems, contributed to your inability to recover fully? ☐Yes ☐No
        i. If yes, please explain why? ____
        ____
        ____
    b. In your opinion, have any of these health problems, contributed to the severity of your injury? ☐Yes ☐No
        i. If yes, please explain why? ____
        ____
        ____
    c. In your opinion, have any of these health problems, actually caused the current injury or medical problem? ☐Yes ☐No
        i. If yes, please explain why? ____
        ____
        ____
35. Are there any personal problems in your life which are contributing to your existing injury or claimed disability? ☐Yes ☐No
    a. If yes, please explain why? ____
    ____
    ____
36. Are there any personal problems in your life which have caused your existing injury or claimed disability? ☐Yes ☐No
    a. If yes, please explain why? ____
    ____
    ____

Applicant's Name_______________________________

Other Information (Please Initial Each Statement)

__________ I understand if I am reemployed by a state agency in a position which is covered by OLERS my retirement payments shall be suspended until I retire and I am no longer employed by a state agency in a position covered by the OLERS.

__________ I understand it is my responsibility to inform OLERS in writing of any changes in my disability which would enable me to return to full duty and I understand failure to do so will result in fraud prosecution and repayment of benefits I received.

__________ I understand the OLERS Board and will investigate any and all disability claims to the fullest extent allowed. (OLERS v. Shryrock)

__________ I understand as a disability retirement the IRS may investigate my disability claims to determine if they meet the Internal Revenue Code and if found fraudulent I may face Federal prosecution, fines, penalties and interest.

Signature and Notary

Wherefore, applicant requests that he/she be granted a monthly pension in accordance with Oklahoma Statute Title 47, Sections 2-300 through 2-315 to be paid from the Oklahoma Law Enforcement Retirement System in accordance with the laws of the State of Oklahoma.

Date ______________________ ____

Applicant's Signature

The Applicant stated above has attested that he/she has read this application, knows the contents thereof, and that the statements contained therein are true and correct.

Subscribed and sworn before me on_______________________. State of_________________

Notary Signature______________________________ County of _______________

Notary Title (and Rank) ________________________

My Commission Expires on______________________

Commission #________________________________ (seal)

Submission Information

Completed form can be sent to OLERS via:

Mail: 421 N.W. 13th, Suite 100, Oklahoma City, OK 73103
Fax: (405) 522-5004
Email: forms@olers.ok.gov